Improving Veterans MSK Rehabilitation Report

January 2023
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Foreword

The principles of the Armed Forces Covenant have been embedded into the NHS Constitution. These principles were enshrined in law through the passing of the Armed Forces Act 2021, meaning veterans and the wider Armed Forces community should enjoy the same standard of and access to healthcare as that received by any other UK citizen in the area they live.

My vision remains the same as embodied in the Armed Forces Covenant – that those who have served in the Armed Forces and who later become veterans should face no disadvantage in the provision of healthcare services. Special consideration should be given (where appropriate) to those who have given most, such as the seriously injured.

In 2021, the Veterans Rehabilitation Project was established to undertake a review of musculoskeletal (MSK) rehabilitation services currently available to veterans across England. Its aim was to identify gaps and variations in provision, highlight best practice, and develop recommendations for improvement.

The most common reason for medical discharge from the Armed Forces is related to MSK injuries. As an orthopaedic surgeon at The Royal National Orthopaedic Hospital, I have been part of a team that has treated serving personnel and veterans with injuries to their knees, hips, shoulders and backs.

The Chavasse report (2014)1 highlights that serving personnel are able to access world-class Defence Medical Services for MSK disorders. These exemplary care pathways are in stark contrast to the significant variation and disadvantage identified in the report in the diagnosis, treatment and rehabilitation services for veterans with MSK disorders. I felt that we needed to address this through the Veterans Rehabilitation Project, which was funded through the NHS England Armed Forces Healthcare Commissioning Team and is hosted through the Royal National Orthopaedic Hospital (RNOH). The project aligns with the work of the Veterans Covenant Healthcare Alliance (VCHA) (see page 5) and forms part of the wider NHS England Armed Forces Forward View transformation programme.

Through positive engagement with rehabilitation service providers and broader services during the past year, I believe we have established that there is the will and ability to make significant improvements in patient outcomes through a fresh, patient-centric approach.

I would like to thank Maisy Provan (physiotherapist) and Sarah Barker (occupational therapist) for their commitment and hard work carrying out the research and review for this project. Despite COVID-19, they have proposed a new model of care, which in addition to rethinking the rehabilitation environment, would deliver vastly improved MSK rehabilitation care across NHS England. In turn, this would impact positively on all veterans who require MSK rehabilitation and improve care for all NHS patients.

I remain convinced that by improving MSK rehabilitation services for our veterans, it will raise standards for all our patients that use the NHS. Let’s now help our veterans by doing our duty in making the UK the best place in the world for them to be.

Professor Tim Briggs
Chair of the VCHA and the GIRFT Programme
Colonel (Hon) 202 Field Hospital (Midlands) RAMC

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1 http://www.thechavassereport.com/Downloads.html
Introduction from the author

Leading this review of MSK rehabilitation services for veterans has been a great opportunity to meet with clinicians up and down the country, in a wide variety of settings, from MSK rehab units and pain services to community and primary care. It was a pleasure to hear and learn from the experience of physiotherapists, occupational therapists, psychologists, specialist nurses, consultants and managers, who work in these services every day.

We also engaged the wider community of professional societies, academia, charities and veterans themselves, who gave us valuable insights in focus groups and interviews.

One of the first questions we had to answer was on the scope of the project. Why look at all veterans differently to the wider population when it comes to MSK rehabilitation? While some will have serious service-related injuries, others will have injuries, conditions and physical health needs that are very similar to any other patient presenting to their GP or outpatient appointment.

Whilst this is true, up to a point. However, it does not take account of the complex intersection of challenges that relate back their experience in the forces, which may include mental health issues, difficulties transitioning to civilian life, or problems with housing and employment. All of these factors can complicate their experience of health services, requiring a different approach to achieve recovery.

Our stakeholders asked us to focus on all veterans, whether their rehab needs are complex or routine, service-related or not. Wider changes to rehab services for all MSK patients were not within our scope. However, it has been recognised that there is a lot of overlap and would be delighted if some of the changes we have recommended for veterans could also improve services for everyone with MSK rehabilitation needs.

During our site visits and virtual meetings, we heard inspiring examples of good practice – some of which are highlighted as case studies in the report. But we also heard frustration at the current state of services. Some staff told us that rehab felt like a neglected service with fewer facilities and resources than in the past, while veterans told us of a lack of co-ordinated care and a risk of getting lost in the system. There was a general feeling that rehabilitation was over-medicalised with a fairly rigid one-size-fits-all approach that is overdue for change.

Our considerations are focused on rethinking the model of care to be more person-centred and holistic. Services could be better coordinated, with earlier triage and more multidisciplinary team (MDT) involvement, and in many cases more patients could be managed in the community. Veterans could also have greater control over their own care and easier access to a range of services; from socially prescribed activities to self-management digital apps and tools, to help them back to full functionality and a more productive, enjoyable life.

We would like to thank everyone who has contributed to developing this report and those who have shared their views and experiences to inform our thinking and recommendations. We hope that it will help to drive improvement and deliver better outcomes for patients in the years ahead.

Maisy Provan

Maisy Provan

Maisy Provan is a physiotherapist and a captain in the British Army Reserves, serving with the Royal Army Medical Corps (RAMC). She has worked in two NHS acute trusts, in Oxford and Brighton, and has a wide range of experience in rehabilitation in the NHS. She now works for the Royal National Orthopaedic Hospital (RNOH) leading on the Veterans’ Rehabilitation Project under the governance of NHS England. Alongside her work, she is studying for an MSc in Trauma Science at the University of Birmingham.
Executive summary

Musculoskeletal (MSK) conditions are the most common medical reason for discharge from the Armed Forces\(^2\). Many of the injuries sustained in combat can result in loss of limbs requiring amputation and prosthetics, with other prevalent MSK issues including hip and groin pain, bone and joint injuries and spinal and neurological disorders. These issues may develop into long-term health problems.

When transitioning from the Armed Forces, veterans lose access to ‘gold standard’ MSK rehabilitation covered by the Defence Medical Service (DMS). The DMS is an occupational-based healthcare with excellent purpose-built facilities and no waiting lists or complicated referral systems, and the medical staff understand the types of injuries and illnesses that arise from active service (see appendix A).

On leaving the service, veterans with MSK injuries or conditions find themselves in a very different world. They must access and navigate NHS services, which can be difficult, especially for those with chronic ongoing needs that relapse periodically and deteriorate with time.

The Veterans Rehabilitation Project was established in 2021 to provide a clear picture of the current MSK rehabilitation services available to veterans across England. By understanding where there are gaps and variations in provision, and learning from best practice examples, it set out to develop key recommendations for improvement and inform NHS Trusts on how they can better serve veterans.

Joined-up approach to provisions for veterans

Both the Veterans Trauma Network (VTN) and the Veterans Covenant Healthcare Alliance (VCHA) play key roles in supporting veterans with MSK injuries or conditions.

The VTN is an established NHS Provider Collaborative virtual network of clinicians in 18 acute trusts including the major trauma centres who work closely with therapists, Op COURAGE: The Veterans Mental Health and Wellbeing Service and charity representatives. It provides a centralised, multidisciplinary approach to treatment and referrals for those with complex service-related injuries, ensuring veterans are directed to the right services.

The Veterans Covenant Healthcare Alliance (VCHA) aims to accredit every acute and community trust within the NHS to become Veteran Aware. This will allow the majority to be seen within their local NHS services where trusts are aware of veterans needs and are committed to providing ‘Veteran Aware’ care. This will allow the local co-ordination of care for veterans, working together with and supporting referrals to a range of specialist services, such as Op COURAGE.

Key findings

The following key findings draw on the many best practice examples we found and take into consideration a vast range of feedback from physiotherapists, occupational therapists, psychologists, specialist nurses, consultants and service managers, who work in these services every day, and from veterans themselves.

Education and awareness

There are few MSK rehabilitation services for veterans that recognise their physical and mental health needs, and relatively low awareness of veterans and their needs among NHS trusts. On our site visits, we found that many clinicians on the ground had little awareness about the health needs of veterans and whether they had veterans as patients.

Identifying veterans in the health system

When a service leaver registers with a GP, their medical notes are not automatically transferred from the Ministry of Defence (MOD). When veterans change GPs, their veteran status, if known, is often not communicated to the new practice. As a result, many GPs do not know if their patients are veterans. Veterans told us this continues when they are referred to other services in secondary and community care.

Co-ordination and communication

Many of the veterans we spoke to with MSK injuries and conditions cited co-ordination and communication as a barrier to good healthcare. We heard a common complaint that they had to repeat the same information to multiple staff or services. Many felt they were left to co-ordinate their own care. They found this particularly difficult, without knowing the structure or functions of NHS services and the different roles of medical staff and allied health professionals (AHPs).

Regional variation in services

Some of the veterans we spoke to said rehabilitation follow-up and support was uncoordinated in their local area or did not match their needs. This may relate, in part, to the fact that all MSK rehabilitation is commissioned locally and is not always joined up with centralised services.

Lack of vocational rehabilitation

In our site visits and meetings, we saw a general lack of vocational rehabilitation in the NHS for all patients; veteran and non-veteran. The focus was on reabling people to do things like walking or climbing stairs, rather than rehabilitating them back to a higher functioning level. Mind-body interaction is a key player in rehabilitation, especially for veterans whose experiences in active service can be devastating – and yet the two are still often treated separately.

Variation in pain services

Pain is often the primary concern for veterans with service-related injuries and chronic MSK conditions. We found significant variation in how pain services are organised. In different trusts, they may sit with rehabilitation, in a separate pain management unit, or under a different speciality, such as rheumatology. Waiting times in many areas are high.

A proposed new model of care

The existing model of care needs to be rethought with the veteran at the centre, using a variety of approaches, based on individual needs and goals. The considerations we are proposing are broadly in line with the initial work of the Best MSK Health Collaborative, an NHS England initiative to improve services for all MSK patients and ‘build back better’ post-pandemic.

The proposed model is set out in detail later in this report and includes the following considerations:

- Early triage and referral
- Centring care for chronic conditions in the community
- Strengthening multidisciplinary teams (MDTs) for complex patients
- Staff recruitment and retention
- A veterans’ passport should be developed giving veterans a patient-held document that summarises their health history, which they can hand over at each new appointment.
Considerations for NHS trusts

Based on the best practice examples we have witnessed, and to address the gaps in care identified in this report, we have developed the following set of considerations for NHS trusts.

- All trusts should become Veteran Aware.
- All NHS staff (from GPs to hospital ward clerks or receptionists) should undertake basic veteran awareness training, which should be included in the induction package for new staff and then form part of mandatory training requirements.
- Dedicated Armed Forces champions should be appointed in each health service. The Armed Forces Champion role is to raise the profile and needs of the Armed Forces community (Regular and Reserve, Families, Veterans, and Cadets), internally and externally with the Trust. In addition the Armed Forces Champion is to work closely with senior members of Trusts Dyad staff, with particular reference to, the Trusts obligations undertaken through the Armed Forces Covenant.
- All patients should be asked if they have ever served in the Armed Forces. This information should be recorded and subject to consent, services should share this information throughout the care pathway.
- Veterans with complex and enduring physical and/or mental health conditions should have a designated key worker as a single point of contact in primary care.
- NHS service providers should encourage veterans to use the national digital Summary Care Record and Patient Health Record. The record summarises their health history, which they can hand over at each new appointment.
- A minimum of two outcome measures should be used for MSK rehabilitation, chosen to meet and reflect patient goals and needs. Services should regularly review performance against these measures and make improvements as needed.
- MSK rehabilitation services for veterans should aim for full vocational rehabilitation rather than limited reablement, with clearly defined goals and expectations set out in a rehabilitation plan agreed with each patient.
- Veterans presenting with MSK injuries in primary care should be referred to the VTN for a MDT personalised and holistic rehabilitation needs assessment, including physical, cognitive and psychological functioning.
- Rehabilitation for veterans with chronic, but not acute, MSK conditions should be managed in the community, with access to multidisciplinary care and a variety of services, such as gyms, classes and social prescribing, and the freedom to access rehabilitation services when needed without another referral.
- Veterans with complex and disabling conditions should have their ongoing care managed by MDTs, in line with NICE recommendations. MDTs should include physiotherapy, occupational therapy, psychology and conditioning specialists. MDTs should consider involving MSK rehabilitation centres who have a reputation for specialised rehabilitation services.
- NHS trusts should look to attract a wider range of allied health professionals to join MSK rehabilitation MDTs and make more allocated time for CPD and training. Staff should be involved in quality improvement processes so they can help deliver changes within the service that they work in.
Background, method and approach

The scope of the Veterans Rehabilitation Project was set out by the national NHS England Armed Forces Healthcare Commissioning Team and Professor Briggs. The Chavasse Report⁴, published in 2014 by Professor Briggs, highlighted the need to improve veteran healthcare. The report acknowledged the lack of rehabilitation for Armed Forces veterans once discharged compared to world-class rehabilitation centres within the Armed Forces.

What is rehabilitation?

The Veterans Rehabilitation Project defines rehabilitation as maximising a person’s physical and mental capacity and returning them to a level of physical, social and psychological function where they are able to realise their own potential.

It is a process depending on the patient’s condition and needs, rather than one form of treatment. It can involve restoring movement, muscle strength and capacity to walk and exercise, as well as reducing pain and symptoms.

Why we need better MSK rehabilitation services for veterans

Musculoskeletal conditions are the most common medical reason for discharge from the armed forces⁵ and the leading contributor to disability worldwide.⁶

In general, veterans suffer higher impact MSK injuries than the general population. During the wars in Afghanistan and Iraq, more than 50% of personnel referred to defence rehabilitation had an injury severity score (ISS) above 35 – a scale where 75 means an injury is not survivable. This compares with the majority of NHS patients who have an ISS of between 16 and 24.⁷

Many of the injuries sustained in combat result in loss of limbs requiring amputation and prosthetics. Exposure to complex loads during ‘force generation’ and active service can also cause biomechanical deficits which leads to a high level of hip and groin pain.⁸ Other prevalent MSK issues among veterans include:

- osteoarthritis
- spinal and neurological disorders
- knee pain
- back and neck issues
- lower back pain
- bone and joint injuries

These issues may develop into long-term health problems, often compounded by mental health issues, which can result from the trauma associated with service-related injuries. MSK and mental health are closely interlinked among veterans and need to be addressed together to achieve the best outcomes.

⁴ The Chavasse Report – Timothy Briggs www.thechavassereport.com
⁶ World Health Organization Musculoskeletal conditions (who.int)
⁷ RJ Russell et al 2011. The role of trauma scoring in developing trauma clinical governance in the Defence Medical Services – PMC (nih.gov)
⁸ Cassidy, RP. and Coppack, RJ. et al, Biomechanical and clinical outcomes in response to inpatient multidisciplinary hip and groin rehabilitation in UK military personnel. BMJ Military Health 2021 http://dx.doi.org/10.1136/ bmjmilitary-2020-001588
Differentiating veterans from other MSK patients

Some veterans, especially those with injuries and conditions that are not service related, have the same physical health needs as the wider MSK population.

Due to the nature of their military service, they can, however, face specific challenges, such as mental and physical health issues. Furthermore, they may face difficulties transitioning to civilian life, such as problems with housing and employment, which can complicate their access to health services.

Their experiences of active service and associated life changes may be central to understanding their injuries and potential for recovery and their overall healthcare needs may require a different approach to achieve the same outcomes. This is why non-service-related injuries and conditions were included within the scope of this report.

Methodology

Rehabilitation clinicians Maisy Provan (physiotherapist) and Sarah Barker (occupational therapist) reviewed rehabilitation services across England, including community, outpatient and inpatient programmes, with a particular focus on MSK, pain management and the psychological effects of injury.

They studied the models developed at units currently providing rehabilitation to serving personnel and veterans, and looked for variations and examples of best practice that would help to drive up standards of care.

Site visits and meetings

Throughout 2021, the Veterans Rehabilitation Project team undertook 262 engagements with clinicians (both virtual and face-to-face). Staff who attended included physiotherapists, occupational therapists, psychologists, specialist nurses, consultants and service managers.

During each session, the team presented the project aims and asked participants about their service, how it operates, patient journeys, what works and doesn’t work, opportunities for improvement, and what changes would make the greatest difference, both now and in the long term.

See Appendix, page 34, for the full list of meetings and visits.

Engaging with veterans and stakeholders

The team engaged with veterans in a series of focus groups and one-to-one interviews, to understand their experiences as ex-service personnel and as patients using current rehabilitation services. The review was primarily concerned with MSK rehabilitation service providers in secondary and community care. The team also spoke to GPs, first contact practitioners (FCPs) and social prescribers in primary care. (see Appendix, page 34 for details).
Review of supporting evidence

A range of documents, studies and guidelines on rehabilitation interventions were reviewed and compared to current clinical practice. These included:

- NICE Guidelines
- Previous NHS reports on rehabilitation
- British Society of Rehabilitation studies and documents
- British Pain Society reports and guidance
- Chartered Society of Physiotherapy recommendations
- Versus Arthritis reports
Governance and oversight

The project was guided by a stakeholder group including:

- Professor Tim Briggs, Chair of the VCHA, National Director of Clinical Improvement NHS England and NHS Improvement
- Alison Treadgold, Head of Armed Forces Health (Operations), NHS England Armed Forces Health Commissioning Team
- Andy Bacon, Head of Armed Forces Policy and Strategy, NHS England Armed Forces Health Commissioning Team
- Beth Lambert, Veterans Trauma Network Programme Manager
- Kate Parkin, Director – NHS Armed Forces Community, Lead Sussex and Kent & Medway Armed Forces Networks

A reference group was also created to strengthen the external review and contribute ideas for the project. The group included:

- Alex Crick, NHS Consultant Plastic Surgeon at Salisbury NHS Foundation Trust
- Helen Harvey, NHS Clinical Manager at Bristol Murrison Centre, North Bristol NHS Trust
- Pete Le-Feuvre, Military Physiotherapist and PhD student
- John Doyle, Lead Allied Health Professional, Royal National Orthopaedic Hospital (RNOH)
- Matt Fossey, Associate Director and Professor at Anglia Ruskin University
- Brian Chenier, Prosthetics support officer from Blesma

Evidence and data collection

There is limited systematic recording of veteran status in NHS clinical and administrative systems. Therefore, the majority of data that informed this review came from qualitative interviews. These comprised meetings with service staff and clinicians using set questions for comparison, followed by an analysis of the themes that emerged from meetings.

Online survey

An online survey was created to gather quantitative data about some of the existing NHS services. Responses were received from a variety of related services across England, including MSK rehabilitation, neuro rehabilitation, pain, orthopaedic and psychology, in hospitals and the community. The level of response to the online survey was poor overall and therefore the data was of limited use in drawing conclusions and formulating recommendations.
The veteran population and current services

A veteran is anyone who has served in the British Army, the Royal Navy, the Royal Marines or the Royal Air Force, as either a regular or reservist, for at least a day, as well as merchant mariners who have seen duty on military operations. Current reservists who are not mobilised also have the status of veteran until they return to active service.

The age range among veterans reflects very different experiences of the Armed Forces, from those who served in Iraq, Afghanistan or Northern Ireland, to those who have never deployed on military duties.

Military service has both positive and negative effects on health. In general, military personnel are likely to be healthier and fitter than civilians of the same age in the earlier years of service, as a result of the rigorous demands of military training and service, often termed the 'healthy soldier effect'.

Long-term care needs

The long-term impact of active service can take its toll as service personnel put higher demands on their bodies than most civilians, especially on the MSK system. Armed forces veterans who need rehabilitation tend to have suffered higher impact MSK injuries than the general population and have greater rehabilitation and support needs.

Veterans can face mental and physical challenges that relate back to their experience in the forces, and encounter problems adapting to civilian housing and employment, which complicate their access to and experience of health services.

Although healthier earlier in life, they begin to fall behind their civilian counterparts during the middle years on some MSK outcomes. Veterans aged 35–49 are significantly more likely than non-veterans to report problems with:

- back or neck related conditions (34% vs 23% of same-age civilians)
- leg or feet related conditions (33% vs 20%)
- arm or hand related conditions (22% vs 13%)

Some veterans may also suffer the consequences of a heavy drinking and smoking culture in the Armed Forces in later life, although this impact is likely to reduce among newer veterans as awareness of the effect of lifestyle on health grows.

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Regional variations

The heat map below shows the distribution of veterans with MSK health conditions across the UK. They tend to be clustered in areas where there are large Army or naval bases, cities in the north and rural areas of England – places that are not always well located for MSK rehabilitation services.

For example, many veterans live in Cornwall, where there are only two NHS trusts. Rehabilitation services are often provided in satellite clinics which can be hard to get to. Staff retention issues mean it can be difficult to get regular appointments or waiting lists become longer. In other counties, trusts lean on neighbouring service, but this is difficult in Cornwall due to its geography.

Virtual appointments and follow-ups can be offered, but in many cases physical presentation is essential to properly assess people’s injuries and needs (see Learnings from COVID-19, page 25).

Figure 3: Heat Map showing the geographical density of MSK veterans in receipt of MoD disability payments in Great Britain

2.4m veterans living in Great Britain

10 years average time veterans have served in the armed forces

12 The provision of rehabilitation services for MSK armed force veterans in the UK and constituent countries, final report 2015 www.phast.org.uk
Current MSK rehabilitation services for veterans

Only 20% of those who answered our survey, which was sent to all NHS MSK rehabilitation providers via VCHA regional leads, said they had specific services for veterans. These are mostly for amputees and provide specialist continuing services for veterans who were fitted with prosthetic limbs because of injuries during active service.

In most cases, veterans access the same MSK rehabilitation services as the general population with little or no differentiation of them, their injuries or mental health needs. This can lead to poor engagement with their healthcare and cause them to get lost in the system – see Smoothing the transition to civilian healthcare, page 17.

Services for amputees – the Veterans Prosthetics Panel (VPP) and disablement service centres

The NHS is funded to provide high-quality prosthetic limbs to veterans through the VPP. Dedicated slots are held open for veterans in some hospitals, including a network of disablement service centres (DSCs) specially equipped for veterans.

Nine DSCs are now known as Murrison centres14 where veteran patients can access specialist services without waiting, including ongoing care and replacement of prosthetic limbs when required.

The Defence and Medical Rehabilitation Centre (DMRC)

DMRC is a major MOD-run clinical rehabilitation centre for Armed Forces personnel and some veterans. Currently veterans with complex prosthetics socket needs can access services at DMRC.

The Veterans’ Orthopaedic Service

This special service, based at the RJAH Orthopaedic Hospital in Shropshire, provides hip and knee replacement surgery for veterans with arthritic lower limb problems.

The Veterans Trauma Network (VTN)

The VTN is a network of specialist clinicians linked to 18 trauma centres located at NHS trusts across England. The network deals with veterans who have complex physical healthcare issues as a direct result of their time in service.

The RNOH veteran MSK rehabilitation service

Currently planned to open in 2023, the new rehabilitation unit at the Royal National Orthopaedic Hospital (RNOH) will be the first rehabilitation programme of its kind with dedicated veteran beds and a holistic outpatient service.

Independent providers

In some areas of England, the NHS commissions organisations from the private sector to provide rehabilitation services. This might happen where the local NHS does not have the capacity to deliver higher level ongoing rehabilitation.

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Veterans charities

Service charities play a vital role, including delivering care and support, driving research to better understand the needs of the veteran population, and providing advocacy for the Armed Forces community.

They help veterans to access existing NHS services, co-ordinate their care, and navigate the health system. In some cases, they may also help to fund private rehabilitation care where a specific need can’t be met by the NHS.

A full list of service charities can be accessed through searching on The Confederation of Service Charities (Cobseo) website\(^1\).

Figure 4: Rehabilitation sits within a network of services that can all potentially contribute to veterans’ recovery including primary and community care, mental health services and veterans’ charities, supported by accreditation schemes such as Veteran Aware for hospitals and the veteran friendly GP scheme (see page 22), as shown below. However, many veterans find it difficult to know what’s available to them and to access and navigate this landscape.

\(^1\) https://www.cobseo.org.uk/members/directory/
**Veteran services around the world**

There is wide variation in healthcare for veterans in other countries. For example, in the USA there are dedicated veteran hospitals that specialise in treating service-related illness and injury, although this is in the context of a system which does not normally provide free access to healthcare. Canada, Australia and France are also known for having good services for veterans.
Smoothing the transition to civilian healthcare

When people leave the Armed Forces, it can be a difficult transition for some. They may feel a sense of loss or bereavement. It can seem like not only losing a job, but leaving behind a family, comradeship, housing and people who can empathise and 'speak their language'.

The difficulty of transitioning from this service was highlighted in the Chavasse report as a problem that needed fixing.

Barriers preventing veterans from rehabilitation

Health literacy issues
Some veterans may have low 'health literacy', which means they may struggle to understand health information and make choices about their healthcare. They may be used to following orders and find it difficult in situations where they have to make complex decisions about their healthcare.

Reluctance to see a GP
We found that many veterans delay seeking care for their conditions, which may deteriorate as a result. They often try to 'push through the pain', don't want to burden the NHS or hope the problem will go away on its own. Rather than going to their GP, some veterans wait until things are so bad that they end up at the emergency department.

This was reflected in our survey of NHS MSK services, as shown in the key findings in the below table. The services that responded received a larger proportion of referrals (43.3%) from emergency or other hospital departments than from GPs (36.7%).

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<th>Proportion</th>
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<td>GP</td>
<td>10%</td>
</tr>
<tr>
<td>Acute provider</td>
<td>36.7%</td>
</tr>
<tr>
<td>Other service</td>
<td>43.3%</td>
</tr>
<tr>
<td>Self-referral</td>
<td>10%</td>
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Mental health issues
Many veterans with service-related injuries also suffer from mental health issues, including post-traumatic stress disorder (PTSD), which may be directly related to the trauma associated with those injuries. This further complicates their engagement with NHS services.

A joint approach between health services and Op COURAGE: The Veterans Mental Health and Wellbeing Service, for people leaving the Armed Forces and veterans, could help to reduce this stigma of having to seek help.

Getting lost between services
We heard from some veterans who felt that they were caught in a ‘Catch 22’, unable to access or engage with physical rehabilitation services because their mental health issues had not been resolved, yet unable to comply with their mental health treatment because they were still suffering significant physical pain or incapacity. These patterns were also reflected in some clinic letters from VTN MDTs.

Some of these patients are at risk of getting lost between mental health and MSK services and entering a downward spiral. To help address this, the VTN is working with Op COURAGE and military charities to establish stronger links.
Other barriers to veteran rehabilitation

Our research identified gaps in awareness and understanding between health professionals and veterans, which can be a barrier to effective rehabilitation services.

- Clinicians often don’t have a strong understanding of the military community and the problems that veterans face.
- When veterans don’t feel listened to, they often disengage with their rehabilitation. Getting veterans on board with their treatment is vital to inspire self-motivation and compliance.
- Veterans may not understand the roles of different professionals in the NHS and may not seek medical help. They may have issues with language and literacy.

A lack of co-ordinated care

Many of the veterans we spoke to with MSK injuries and conditions cited poor co-ordination as a barrier to good healthcare. The issues start with the transferring of medical notes from the Defence Medical Services (DMS) to GPs, where there is a high level of inconsistency in access to notes from time in service. Some GPs we spoke to were not aware of the medical history of their patients who are veterans. Veterans told us this carries through when they are referred to other services. Some veterans do not have a good relationship with their GP and can struggle with the health system because GPs are the gatekeepers to secondary care and other services.

These issues are being addressed through the Royal College of General Practitioners (RCGP) veteran friendly GP practice accreditation programme – see page 22.

Feedback on navigating the health system

During small focus groups veterans gave a range of feedback about their experiences of using and navigating NHS services:

- Some mentioned poor communication between different NHS departments and services, which they found frustrating. This led to a common complaint that they had to repeat the same information over again to multiple staff or services.
- Many felt they were left to co-ordinate their own care. They found this particularly difficult, without knowing the structure or functions of NHS services and the different roles of medical staff and AHPs.
- For some, there was a lack of explanation or follow through, which they felt was overwhelming and frustrating.
- There was also frustration about the high turnover of staff, as veterans built up relationships and rapport with staff members who left. Some veterans expressed the feeling that healthcare staff were not carrying out joined up working, adding to frustrations.
- Veterans spoke highly of the rehabilitation and treatment they received during their time in service, with particular praise for the occupational therapists.

The need for a single point of contact

Veterans with chronic or long-term MSK or other long terms conditions felt as though they needed a point of contact to co-ordinate their care. Co-ordination by a key worker has been shown to work for people with other chronic conditions. For example, people with diabetes are assigned a diabetes nurse in the community who is their main point of contact. This allows other clinicians to focus their time and attention on treating patients, while patients feel they have an advocate who is looking out for their best interests.
The role of the VTN

The VTN is a provider collaborative that operates across England made up of 18 acute trusts including the major trauma centres. Many of the acute trusts have military clinicians in their workforce. The collaborative works closely with OP Courage the Veterans Mental Health and wellbeing service and the Armed Forces Charity sector. It provides a single point of contact and a centralised multidisciplinary approach that co-ordinates treatment and referrals for those with complex service-related injuries, making sure that veterans are directed to the right services.

The majority of veterans with MSK needs can be seen locally in a VTN collaborative provider trust. All VTN trusts are also VCHA accredited.

A veterans’ health passport

Some veterans expressed a desire for a health passport containing relevant information which they carry with them to each new appointment – this is in line with NICE guidelines.16

While several veteran passports exist one has been trialled in a pilot project called The Veterans Universal Passport (VUP). This particular passport was developed by Diane Palmer, formerly of the Veterans’ Mental Health Transition, Intervention and Liaison Service (TILS) for the Midlands and East of England.

Veterans transitioning to civilian life took part in the pilot and reported improved continuity of care and a feeling of control over their care. Participants also said the passport increased their sense of identity and helped them negotiate the complexities of the civilian healthcare system.

Education for NHS staff and veterans

Some of the issues with co-ordination of care could be resolved if there was greater awareness of veterans in the health system. This would enable healthcare professionals to make better links with veterans’ services, both NHS and charities.

Our colleagues in the Veterans Covenant Healthcare Alliance team (VCHA) undertook a mystery shopping exercise in some trusts and found that the simple question ‘Have you ever served in the British Armed Forces?’ is not routinely asked.

Identifying veterans in the health system

When a service leaver registers with a GP, a letter is automatically generated informing the GP that their new patient has been under the care of Defence Medical Services. As with the rest of the population, GPs have to request the patient’s medical notes from the DMS or the NHS practice a veteran may be transferring from – they are not automatically transferred.

The RCGP continues to work on raising awareness within primary care and providing a more seamless pathway for veterans accessing NHS services. GP practices can record veteran status using a READ code so that the veteran status will remain on their record should they change practice.

Asking patients if they’ve served

As a minimum, GPs need to ask patients if they have served in the Armed Forces and record the response on the system, while respecting their right not to disclose. Ideally, they should also be asking follow-up questions about their circumstances, housing, employment and mental health, which may all have changed when they left the Armed Forces and may be linked to their physical condition.

Ensuring staff undertake training on Armed Forces health will help them to build a rapport with veterans and ultimately provide a better service. Many of the clinicians we spoke to on our site visits said how useful it would be to have some staff training and a resource library to learn more about the Armed Forces community.

16 NICE Guideline, Rehabilitation after traumatic injury, Developing a rehabilitation plan 1.4.3 www.nice.org.uk/guidance/ng211
Managing service leavers’ expectations

Veterans also need education about the structure of the NHS and the roles of different staff to manage their expectations when transitioning from the DMS. There can be a sense of entitlement, which leaves them frustrated and disappointed with the everyday realities of the NHS.

The MOD provides transition courses for service leavers which explain how some NHS services work and what will be available to them. It is essential that DMS interact and communicate with NHS services to ensure seamless transition, especially for those with significant ongoing rehabilitation needs, otherwise many of the gains made whilst serving could be lost. Integrated Personal Commissioning for Veterans (IPC4V) has already helped to bridge this gap for those with complex and enduring physical, neurological and mental health conditions.17

17 https://www.england.nhs.uk/personalisedcare/upc/ipc-for-veterans/
Improving MSK rehabilitation services for veterans

We looked at a range of NHS MSK rehabilitation services to understand how they address veterans’ specific physical and mental health needs.

Variation in rehabilitation services

Services for amputees

Disablement service centres, including Murrison centres, provide multidisciplinary support for amputees. These services are nationally funded and provide care, including ongoing rehabilitation, for veterans across the country for as long as they need it.

We saw evidence of variation in services for amputees in our site visits and meetings. Some trusts offered ringfenced time slots for veterans while others did not allocate dedicated slots but did make longer appointments. Peer support was available for amputees in some places, but not in others.

Specialist MSK veteran services

For veterans with other complex physical health issues, the VTN – see page 14 – provides a multidisciplinary assessment and helps them see the right person at the right place for their needs. It does not, however, provide rehabilitation services directly and must refer patients with MSK rehabilitation needs on to other services.

The veterans we spoke to said they were willing to travel to access specialist services where the staff were trained to deal with service-related injuries and health problems. Veterans advised, however, that when they returned to their local area, rehabilitation follow-up and support was uncoordinated or did not match their needs. Some of these issues relate to the fact that all MSK rehabilitation is commissioned locally and not always joined up with centralised services.

Ad hoc services

Apart from the limited circumstances described above, the majority of veterans with MSK rehabilitation needs must access NHS services in the same way as any other patient. There is often no awareness of their veteran status and no attempt to address their physical health needs in the context of their service history, or the mental and social challenges they face as a result.

We saw some excellent examples of veteran-specific care in our site visits and meetings – some of which are featured in case studies in this section. These tended to rely on the effort of individual staff – often veterans themselves – rather than as part of an established care pathway, which is preferable.
Veteran Aware accreditation

The Veterans Covenant Healthcare Alliance (VCHA) has been set up to raise awareness of veterans and the Armed Forces community within NHS trusts. The aim is that all NHS Trusts will be aware of veterans and their responsibilities towards them by March 2023.

As of September 2022, 123 NHS trusts signed up to the VCHA Veteran Aware Accreditation scheme,\(^ {18}\) which is more than 55% of all NHS trusts across England. The rate at which trusts have joined is increasing, with more yearly service reviews and requirements to evidence good practice. The VCHA is now recording evidence of the impact of accreditation on patient care through patient stories and evidence from trusts. It is aiming to achieve accreditation of 75% of NHS trusts in England by 2023.

The Royal College of General Practitioners (RCGP) is also working with NHS England to accredit GP practices as ‘veteran friendly’. Over 1,500 GP practices in England are accredited through this programme, which provides practices with an information pack to help increase their understanding of the health needs of veterans.

**Online survey – Is your service VCHA accredited?**

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Variation in pain services

We found significant variation in how pain services are organised. In different trusts, they may sit with rehabilitation, in a separate pain management unit, or under a different speciality, such as rheumatology. Waiting times in many areas are high with veterans, living with chronic pain, among those waiting up to two years for treatment.\(^ {19}\)

There is also wide variation in service delivery across the country.\(^ {20}\) Trusts variously offer pain clinics, pain management programmes or pain rehabilitation, and these services differ in their set-up, staffing and resources. These findings broadly echo the British Pain Society’s Pain Audit Report.\(^ {21}\)

The main issues we identified in our site visits and meetings include:

- Appropriately skilled staff are often not available to deliver treatment.
- MDT working is limited or teams are not joined up.
- Pain services are not well integrated with other services which means patients face longer waits when they are referred for specialist advice.
- Information on pain is not delivered in a way that many patients can grasp the essentials.
- The work has not been done to assess the impact of improved pain management on other aspects of the healthcare system.
- We were told there is little or no national oversight or regional leadership to promote quality specialised pain care.\(^ {22}\)

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\(^ {18}\) https://www.england.nhs.uk/personalisedcare/ipc-for-veterans/veteran-aware-nhs-trusts


Improving Veterans MSK Rehabilitation Final Report 2022
The role of pain management programmes

Pain management programmes use education and practice sessions, usually in group sessions, to help people with persistent pain to manage their pain and everyday activities better. They are usually managed within an MDT, with a focus on a biopsychosocial approach that is suited to the needs of individuals.

While only some of these programmes have so far demonstrated efficacy, there is evidence that they can help some patients. They give people tools such as mindfulness training to help them self-manage their condition, as well as supporting them to develop interests and undertake challenges to distract from the pain, drawing on self-motivation.

Some areas of the country offer escape pain programmes – an evidence-based MSK pain rehabilitation programme – in NHS settings or local leisure centres. This allows people to re-integrate into the community while having rehabilitation in a non-medical environment.

MSK rehabilitation in the NHS in England

MSK rehabilitation services vary across England. In some places it is provided in one hospital, in others it is divided between hospitals, GP practices and community services.

The majority of services we reviewed are hospital-based and run by physiotherapists in outpatient departments. Patients are either referred via their GP or through secondary care, with some self-referrals, depending on local practice.

Most units were set up with physiotherapy plinths or couches, with services provided on a one-to-one basis, with few classes or group activities providing peer support. Most patients have an initial 45-60-minute assessment, with up to five 30-minute follow-up appointments.

**Gaps in MDTs**

Multidisciplinary working was limited with a narrow range of medical and AHPs on MSK rehabilitation teams, or members of MDTs located in different sites and buildings so that they were not easily available.

Few services offered occupational therapy and even fewer had psychologists as part of the MSK rehabilitation team. Often it was not possible to refer patients to a psychologist in another part of the hospital. Furthermore, some patients were signposted to services without a managed referral.

**Variations in community care**

Rehabilitation can be provided in the community through local clinics or GP practices – with healthcare workers coming into people’s homes where needed. This helps patients who are immobile or find it hard to access hospital services.

However, we found the community rehabilitation model is not well developed. Rehabilitation is provided in the home, and services are often designed around reabling elderly people after falls. Staff may not be equipped to support patients who need full functional rehabilitation, or those with specific needs.

**Restricted access to specialist centres**

Specialist rehabilitation centres are intended to provide intensive rehabilitation care outside of an acute hospital for people with a disabling condition – to enable them to recover function and regain a level of independence long term.

We found that these were almost exclusively for patients with neurological and spinal disorders, and they are not the set up for people with chronic MSK conditions.

Continued on the next page...
Regional variation

Within the NHS, we found that the facilities and services available for MSK rehabilitation depended on where people live. Some services offer exercise classes for patients with osteoarthritis, upper limb and back pain, but in some places patients are directed to online exercises or leaflets with exercise instructions.

A need for investment and prioritisation

We heard from MSK rehabilitation teams that rehabilitation facilities, such as gyms and equipment, have been cut in recent years where trusts were looking for budget savings or seeking space for beds or offices. This reduces the capacity to offer a full range of rehabilitation services.

Staff training and retention

Staffing levels were generally low with high numbers of vacancies in some areas. This leads to staff being under pressure and feeling that they can’t provide the full scope of service they would like to. Appointment times are generally short, waiting times long and staff are under pressure to discharge patients quickly.
A proposed model of care for MSK veterans

MSK rehabilitation services in England are not always meeting the needs of all veterans with complex MSK conditions. Care is good for amputees and there are well-established services for those with brain and spinal injuries. No well-established care pathways were found for other veterans with MSK injuries and conditions, although some physical health pathways are now being developed.

The existing model of care needs to be rethought with the veteran at the centre, using a variety of approaches, based on individual needs and goals. The following considerations we are proposing are broadly in line with the initial work of the Best MSK Health Collaborative, an NHS England initiative to improve services for all MSK patients.

Learnings from COVID-19

COVID-19 demonstrated the need for efficient, effective rehabilitation services. When the pandemic began and beds were needed, rehabilitation support was vital to get patients mobile and discharged safely. Likewise, the emergence of long COVID demonstrated the need for rehabilitation to prevent deconditioning and improve patient flow and recovery.

As the pandemic progressed, many units were forced to shut their doors. This challenged clinicians to find new ways to support patients, through pain consultations and blended treatment approaches, with some considering social prescribing and alternative methods of support.

These changes have brought some welcome flexibility into the system and an increased openness to new ways of working. This was, however, counterbalanced by the withdrawal of face-to-face services for all except the most serious cases – in an area of care where physical presentation is often essential.

Early triage and referral

When people who are identified as veterans present with MSK injuries, they should be referred to the VTN for an initial holistic assessment to determine their needs. The majority would be managed locally, with most care delivered in the community and within the local rehabilitation network or a regional rehabilitation unit, such as the veterans rehabilitation unit now being built at the Royal National Orthopaedic Hospital (RNOH). The VTN can link them to the right treatment or service, whether that’s a further medical intervention, a rehabilitation centre, a community service or a veteran’s charity. All VTN NHS trusts are accredited by the VCHA.

Centring care for chronic conditions in the community

Veterans with chronic conditions told us they would like to see more care delivered in primary care with GPs working alongside first contact practitioners (FCPs) – who are generally physiotherapists – practice nurses and community rehabilitation. Local co-ordination could include social prescribing to activities or activity-based recovery programmes offered by veterans’ charities.

Taking rehabilitation away from the traditional environment and into settings, such as leisure centres, could also help them to integrate in their community and develop peer-to-peer support networks – aiding confidence and supporting recovery.
Strengthening MDTs for complex patients

If the case is complex, MSK veterans should have a full MDT assessment to allow a pathway to be created specifically to the individual’s needs. MDTs should be located under one roof rather than having to go to different places to see different members of the same team. This would also promote closer working between team members and enable more ‘corridor conversations’ and ideas for improvement.

There is a need for a wider range of AHPs to be included in MDTs. Some rehabilitation services rely exclusively on physiotherapists, who may not be able to achieve full functional and vocational rehabilitation without the input of occupational therapists, psychologists, social prescribers and others.

Best practice example:
Providing joined up care for veterans in pain

Primary Integrated Community Services, Nottingham

This community-based pain service supports people with chronic pain conditions across a wide area from Nottingham to Newark, with a regular cohort of veterans with MSK injuries.

Patients can be referred via their GP or a hospital consultant. They have a biopsychosocial assessment on referral, which assesses mood and mental health concerns from the outset. This is important for veterans, who may experience anger and feelings of loss having been discharged from the Armed Forces, alongside finding it difficult to pace their recovery.

Patients receive one-to-one support from a pain practitioner, supported by an MDT which includes physiotherapy, occupational therapy, nursing, psychology, pharmacy, wellbeing practitioners and cognitive behavioural therapy (CBT). The team meets monthly to discuss all complex patients.

A six-week pain management programme called ‘Moving on from pain’ is based in local leisure centres. It gives people the tools to self-manage and enables them to reintegrate in the community with education and peer support. Mindfulness, CBT and Tai Chi are available.

Following discharge, patients can self-refer back within a year for any flare-ups. They are encouraged to contact the service directly rather than to go back to the GP. The team keeps a number of ‘SOS’ slots in clinical diaries for this purpose.

Early referral to specialist centres

A short intensive burst of rehabilitation delivered at the time when it is most needed can help people recover function faster, rebuild their lives and ultimately save on subsequent outpatient and inpatient care costs. Their needs can then be managed more easily in the community with less need for specialist intervention. Commissioning groups should reconsider their cost benefit analysis and allow trusts to consider this option in the best interests of patients.

Rethinking the rehabilitation environment

Taking rehabilitation away from the traditional environment would be a good first step in giving patients more control over their care. For example, at the Royal National Orthopaedic Hospital (RNOH) in Stanmore, patients can use the leisure centre as part of the rehabilitation programme.

The escape pain programme works on a similar model in both NHS and leisure centres. This encourages independence and autonomy over health and wellbeing. MSK rehabilitation services could work with local authorities to access leisure centres for ongoing rehabilitation, possibly as part of the new integrated care system (ICS) structures.
Staff recruitment and retention

Low staffing levels are a major contributing factor to gaps and variations in MSK rehabilitation services. We found from our visits and survey results that in many areas, rehabilitation units are staffed solely by physiotherapists. There is a general need to put more effort into regional recruitment and retention to keep existing staff and attract a wider range of AHPs to support effective rehabilitation.

Best practice example:
Creating a hub with services all under one roof

Lancashire Teaching Hospitals NHS Foundation Trust

Preston Specialist Mobility Centre is a one-stop shop which offers rehabilitation alongside prosthetics, orthotics, wheelchair services and maintenance therapy.

It offers unlimited access for veterans and deals with many complications from surgery and illness in the veteran population, including amputees. There are several routes to access services – patients may be referred from their GP or a consultant or they can self-refer or transfer from another specialist rehabilitation centre.

The hub has an on-site gym and a welcoming family atmosphere where veterans can meet others in their situation and build peer support networks. After an initial triage assessment, patients receive a holistic assessment by the physiotherapist, occupational therapist, psychologist and pain team. The centre also offers a repair service for prosthetic limbs.

We heard excellent feedback from veterans on the hub. One travelled from Liverpool to be able to access its services. Another commented on the quality of the communication and the MDT ethos, which means that all her needs were being met.
Figure 5: An illustration of the patient journey through MSK rehabilitation in our proposed model.
Supporting long term recovery

Like most people living with MSK conditions, veterans want to get back to a level of functioning that enables them to live a good life, doing work that gives them purpose and activities they enjoy. The health system should be providing people with the tools and support they need to achieve these aims, both during and after treatment.

Empowering veterans to achieve their goals

Successful long-term rehabilitation requires a commitment from the individual. It often needs a change in beliefs and lifestyle – as well as constant motivation to keep going and working to achieve goals. The rehabilitation journey does not stop on discharge. The challenge is how we inspire people to change and instil behaviours and habits that stick.

Social prescribing to activities and hobbies

Military training makes veterans highly responsive to physical challenge, recreational sports and activities. Often the thing that makes the greatest difference to their long-term recovery is being linked to a hobby they can practice on their own or joining a community activity group.

Veterans charities have long recognised the benefits of activity-based rehabilitation. Many of their programmes are based on helping people learn sports and hobbies and guiding them to get the maximum health benefits from them.

Positive impacts have been reported from people joining local walking groups, learning horticulture and gardening, rock climbing, and arts and crafts. The key aspect of this is patient ownership – the greatest benefit comes from the person doing something for themselves from which they get satisfaction, meet likeminded people and feel part of society.

Example:
Supporting recovery through horticulture

HighGround delivers horticultural therapy service for injured service personnel and veterans at the DMRC. Weekly sessions, held in its dedicated greenhouses and outdoor rehabilitation space, help patients get back on their feet. Skills learned in the sessions include improving standing tolerance, increasing fine motor skills and cognitive processing and improving self-esteem and social interaction.

Being outdoors in the fresh air away from the clinical side of rehabilitation in a safe, peaceful environment, and taking part in meaningful activity, encourages mindfulness and has a positive impact on mental health. HighGround also helps patients develop leisure interests and vocational opportunities and has recently released adaptive gardening guidelines.

Veterans’ Growth in East Sussex, focuses on veterans living with mental health issues, including PTSD. It offers horticulture-based therapy in 12 weekly sessions. Veterans are referred from the Op COURAGE Service and therapy is designed to complement other treatment.

Participants receive a mix of one-to-one therapy and group activity. The courses aim to reduce participants’ levels of stress, anxiety, depression and isolation through physical activity, developing new skills and making long term social connections.
Supporting veterans to self-manage their conditions

In our focus groups with veterans, they told us that they are not listened to. There is too much emphasis ‘on a medicalised approach, doing things to them and not with them’. They should be empowered to manage their own care in ways that are meaningful to them and can lead to long term behaviour change.

Approaches that we found to be successful include:

- Apps and digital resources that guide patients through a program of exercises and allow them to track their progress, boosting motivation.
- Online educational resources that help people learn more about their condition and how to practice safe and effective self-care.
- Ongoing access to gyms and leisure centres where patients can continue to build strength and confidence and access peer support.
- The ability to re-access rehabilitation services if needed without the need for another referral.

Active waiting lists

Active waiting lists and pre-reading resources have also been shown to be useful in developing autonomy and a mind-set of self-care. Patients who are waiting for treatment are given information and guidance relevant to their MSK condition to help learn about that condition or on healthy lifestyle choices or options available in terms of physical activity, nutrition and wellbeing.

Preventing re-occurrence

Giving people back their confidence and ability to participate in society benefits not only that individual but wider society. It can help prevent re-occurrence of MSK-related health issues and help people live better without the need for hospital treatment.

Instilling good habits and behaviours long term can also help people address problems such as obesity, which is common among veterans with chronic MSK disorders and can be a trigger for recurring presentations.

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Financial impact and opportunities

Following publication of this report, we intend to begin a pilot implementation phase of rolling out our recommendations for veteran rehabilitation at chosen sites across the country. We have already received expressions of interest from trusts who want to be part of the pilot. To ensure the best pathway of care the VCHA and VTN will work together in partnership to ensure VTN referrals, once access routes have been clarified, are directed to one of the pilot sites. Both the VCHA and VTN will share developments and progress within veteran rehabilitation.

A further review will look at the evidence from the pilot that could help to inform better rehabilitation practice for people with MSK disorders in the wider population. This will be under the stewardship of Professor Tim Briggs, National Clinical Director for Improvement, and working closely with Andrew Bennet (Non-Clinical Director in MSK) and the Best MSK programme.

We will also advocate for more rigorous evaluation of rehabilitation interventions, so that resources can be focused on giving the most effective treatments to those who will derive the most benefit, and better training for all clinicians working in this area. Training programmes should be developed in close collaboration with all the relevant professional groups and specialties.

In order to maximise the long-term benefits of rehabilitation, we also think that work is needed to address the broader contributing factors to MSK health, including:

- Public health interventions to reduce the future risks of developing MSK conditions.
- Better understanding of the risk factors for longer-term disability with clear routes for the early assessment and intervention for those with severe progressive conditions or severe pain in particular.
- Better use of information systems and technologies and better design of public buildings and private housing to promote independence and self-respect.

Long term objectives and aspirations

As discussed earlier in this report, rehabilitation gyms and facilities have been cut in many areas of the country, or been turned into space for beds or offices. Reinvestment into gyms, patient shared areas, hydro pools, outdoor patient spaces would all reap massive returns.

At the Royal National Orthopaedic Hospital (RNOH) in Stanmore there are plans to build a rehabilitation unit with designated veteran beds. It will be the first of its kind. The unit will bring together MSK and pain rehabilitation services with psychological support and will have the trust’s Murrison prosthetic centre on site.

Based on the results of this pilot, the long-term future may see a network of regional rehabilitation centres that can flex between outpatient and residential set ups, where complex patients with chronic MSK injuries conditions can go for intensive therapy to kick start their rehabilitation and recovery journeys. These should work seamlessly on a tiered basis with primary care and community-based services, which will provide the majority of rehabilitation needs.

The completion of VCHA accreditation across all NHS trusts in England will also help, along with the RCGP veteran friendly GP accreditation scheme. As awareness increases, this will ultimately lead to improvements in care and people living better for longer with their conditions, with less need for presentation at A&E or hospitalisation.
Acknowledgements

We would like to thank everyone who contributed to the development of this report, starting with Professor Tim Briggs who initiated the project and who continues to guide its delivery.

We are grateful to the many colleagues in rehabilitation services across the country who took part in our site visits and meetings for contributing their insights and experience, and to the veterans who participated in focus groups and one-to-one discussions.

We are also indebted to our stakeholder group: Professor Tim Briggs, Alison Treadgold, Andy Bacon, Beth Lambert, Kate Parkin, and NHS England. And to our reference group of Dr Alex Crick, Helen Harvey, Pete Le-Feuvre, John Doyle, Matt Fossey and Brian Chenier.

The research and review process was carried out by Sarah Barker and Maisy Provan. Our data analyst was Ed Bramley-Harker. The report was edited by and/or/if, editor William Higgins.
Appendix

A: MOD rehabilitation services

The Defence Medical Service (DMS), run by the Ministry of Defence (MOD), offers intensive inpatient stays with a structured rehabilitation programme for those with complex trauma, spinal cord injury and traumatic brain injury, as well as a residential rehabilitation programme. Defence rehabilitation is open-ended and not time constrained.

All care is provided through MDTs, including physiotherapists, occupational therapists and exercise rehabilitation instructors (ERIs). Physiotherapists and ERIs are available at every stage from first presentation in primary care. A wider team may be involved, including social work, mental health, prosthetics, speech and language therapy or other support.

MOD tiered approach

**Primary Care Rehabilitation Facilities (PCRFs):** The base layer in defence rehabilitation. Generally located in medical centres, they case manage and treat minor and some moderate MSK injuries.

**Regional Rehabilitation Units (RRUs):** Units providing medical opinion and treatment for patients with moderate MSK injuries, as well as secondary care rehab.

**Defence and Medical Rehabilitation Centre (DMRC), Stanford Hall:** The DNRC offers specialist rehabilitation spilt into sections: neuro, trauma, and force regeneration team. It takes a whole MDT approach with physiotherapists, occupational therapists, ERIs, psychologists, medical doctors and prosthetist.
## B: Full list of meetings, site visits and participants

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<th>Service</th>
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<tr>
<td>Academic</td>
<td>Tom Kersey PhD student researching pain in veterans</td>
<td>Virtual</td>
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<tr>
<td>Academic</td>
<td>Adrian Needs Principal Lecturer in Forensic Psychology at the University of Portsmouth</td>
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<tr>
<td>Academic – Visiting professor at Oxford Brookes University</td>
<td>Derick Wade Rehabilitation consultant</td>
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<tr>
<td>Academic – Anglia Ruskin University, Veterans and Families Institute for Military Social Research</td>
<td>Matt Fossey Associate Professor and Director</td>
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<tr>
<td>Academic Department of Military Rehabilitation (ADMR), DMRC Stanford Hall – MOD</td>
<td>Russell Coppack Clinical Research Manager</td>
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<tr>
<td>Active Plus Cornwall</td>
<td>Danny Daniel – Manager Pete Fox – Lead Instructor Pete Jackson – Instructor Chris Mayer – Instructor Lucy Richards – Project &amp; Compliance Manager: Health Works for Cornwall Richie – Operations Manager</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>Addenbrookes Hospital and University of Cambridge</td>
<td>Sue Robinson Consultant in Emergency Medicine &amp; Associate Lecturer</td>
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<td>Addenbrookes Pain Service</td>
<td>Elsje De Villers Physiotherapist</td>
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<tr>
<td>Arthritis and Musculoskeletal Alliance (ARMA)</td>
<td>Sue Brown CEO</td>
<td>Virtual</td>
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<tr>
<td>Barts and The London School of Medicine and Dentistry, Queen Mary University of London</td>
<td>Jaqueline Rapport Teaching Fellow: MSc in Trauma Sciences. Academic and Pastoral Advisor</td>
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<td>Barts Health NHS Trust</td>
<td>Cat Hilton Physiotherapist &amp; researcher</td>
<td>Virtual</td>
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<td>Battleback Centre – Royal British Legion                                                                                                Chris Joynson Centre manager</td>
<td>Virtual &amp; face to face</td>
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<td>Battleback Staff</td>
<td>Chris Joynson – Operations Manager Capt Christopher Knight – 2IC Ceri Williams – coach Laura Simpson – coach Lyndon Chatting-Walters – coach</td>
<td>Face to face &amp; virtual</td>
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<td>Battling On</td>
<td>Rick Stead – Business Manager Derek Easton – Project Manager Sean Fraser – Veterans Programme Co-Ordinator Nikki Markham – Founding Director</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>Best MSK Health Collaborative</td>
<td>Jane Hart Programme Director</td>
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<tr>
<td>Birmingham Community Healthcare NHS Foundation Trust</td>
<td>Hayley Price</td>
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<td>Jos Van Mulken</td>
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<td>Black Stork Charity</td>
<td>Janet Morrison</td>
<td>CEO</td>
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<td>Blesma</td>
<td>Brian Chenier</td>
<td>Prosthetics Support Officer</td>
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<td>Ceri McDade</td>
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<td>Lisa Ferguson</td>
<td>Counsellor/psychotherapist</td>
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<tr>
<td>British Society of Rehabilitation Medicine Salford Royal NHS</td>
<td>Krystyna Walton</td>
<td>Rehabilitation consultant &amp; President of the BSRM</td>
</tr>
<tr>
<td>Bury NHS Trust</td>
<td>Pain Team</td>
<td>Anna Dalton – Mental Health Services Bury – strategic and opps lead for longterm conditions Psychological medicine David Thompson – physiotherapist, MSK and pain</td>
</tr>
<tr>
<td>Cabinet Office</td>
<td>David Richmond</td>
<td>Independent Veterans Advisor to UK Government Ministers, Veteran, Help for heroes</td>
</tr>
<tr>
<td>Camden MSK</td>
<td>Jonathan Hersey</td>
<td>Programme Lead</td>
</tr>
<tr>
<td>Charted Society of Physiotherapy</td>
<td>Julie Blackburn</td>
<td>Physiotherapist &amp; Professional Advisor</td>
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<tr>
<td>Cornwall MSK NHS</td>
<td>Maria Stickland</td>
<td>Senior Operational Manager</td>
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<td>Cornwall NHS</td>
<td>Andy Craze &amp; Marc Walsh</td>
<td>Armed Forces Social Prescribers</td>
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<td>Darlington Pain Service</td>
<td>Verity Joyce</td>
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<td>Defence Medical Welfare Service (DMWS)</td>
<td>Paul Gaffney, Beverly Young, Abby Dryden, Jessica Liston</td>
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<tr>
<td>Defence Transition Services</td>
<td>Kate McCloughlin</td>
<td>Officer in Charge</td>
</tr>
<tr>
<td>Organisation</td>
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<td>Role</td>
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<tr>
<td>Dorset CCG</td>
<td>Rob Munrow</td>
<td>Senior programme lead, primary and community care team, primary care network lead for the Armed Forces public patient voice advisory group for NHS England</td>
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<td>Dorset NHS</td>
<td>Andrew Gritt</td>
<td>Armed Forces Welfare Service</td>
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<td>Dorset NHS Data Security Centre (DSC)</td>
<td>Tim Randell</td>
<td>Physiotherapist</td>
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<td>East Lancashire Hospitals NHS Trust</td>
<td>Rachel Loftus</td>
<td>Community and Intermediate Care Division</td>
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<td>Ed Bramley-Harker</td>
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<td>Julie Hayley</td>
<td>Manager, Pauline Matthews &amp; Kirsty Allison, Occupational Therapist, Nicholas Dougherty, Physiotherapist</td>
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<tr>
<td>Escape Pain</td>
<td>Isabel Rodrigues de Abreu</td>
<td>Education &amp; Events Manager, project lead, Michael Hurley – Clinical director of the health innovation programme, Physiotherapist by background, Franchesca Thompson – Orthopaedic Research UK Project Lead</td>
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<tr>
<td>Finchale Group</td>
<td>Jacqui Nicolson</td>
<td>Telephone</td>
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<tr>
<td>Fire Fighters Charity</td>
<td>Nicola Pattern</td>
<td>Physiotherapist &amp; Clinical Lead</td>
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<tr>
<td>Getting It Right First Time (GIRFT)</td>
<td>Dr Sridevi Kalidindi</td>
<td>GIRFT Clinical Lead for Mental Health</td>
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<tr>
<td>GIRFT</td>
<td>Keith Gray &amp; Adrian Hopper</td>
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<tr>
<td>GIRFT</td>
<td>Dr Martin Allen</td>
<td>Respiratory Clinical Lead</td>
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<tr>
<td>GIRFT – ED</td>
<td>Dan Bowden</td>
<td>ED Consultant</td>
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<tr>
<td>GIRFT – NHS</td>
<td>Bernadette Knight</td>
<td>VCHA Regional Lead</td>
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<tr>
<td>GIRFT – General Medicine</td>
<td>Phillip Dyer</td>
<td></td>
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<tr>
<td>GP – Barnwell, Cambridge</td>
<td>Dr Rachel Harmer</td>
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<tr>
<td>Guys &amp; St Thomas'</td>
<td>Sarah Austin – Managing Director Integrated and Specialist Medicine</td>
<td>Billy Kelly – Armed Forces Lead</td>
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<tr>
<td>Guys &amp; St Thomas'</td>
<td>Jack Grodon</td>
<td>MSK Clinical specialist physiotherapist</td>
</tr>
<tr>
<td>Guys &amp; St Thomas' DSC</td>
<td>Amy Jones</td>
<td>Physiotherapist &amp; Clinical Lead</td>
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<td>Method of Contact</td>
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<td>Hampshire hospitals NHS foundation trust</td>
<td>Dr Dominic Aldington&lt;br&gt;Pain consultant (ex-Army)</td>
<td>Virtual</td>
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<tr>
<td>Help for Heroes</td>
<td>Carol Betteridge&lt;br&gt;Head of Clinical Medical Services</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>High Ground</td>
<td>Anna Baker Cresswell&lt;br&gt;Charity Founder</td>
<td>Virtual</td>
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<tr>
<td>Hobbs Neurological Rehabilitation</td>
<td>Helen Hobbs&lt;br&gt;Physiotherapist&lt;br&gt;Jen Mellows&lt;br&gt;Speech and Language Therapist&lt;br&gt;Rachel&lt;br&gt;Occupational Therapist</td>
<td>Virtual &amp; face to face</td>
</tr>
<tr>
<td>Horse Heard</td>
<td>Heather Hardy – Trustee &amp; Facilitator&lt;br&gt;Vicky Bennett – CEO&lt;br&gt;Alison Mary Barlow</td>
<td>Virtual</td>
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<tr>
<td>Injured Jockeys Fund</td>
<td>Jayne Matthews&lt;br&gt;Oaksey House Practice Manager&lt;br&gt;&amp; IJF Governance Lead</td>
<td>Virtual &amp; face to face</td>
</tr>
<tr>
<td>Katie Piper Foundation</td>
<td>Johanne Harrison&lt;br&gt;Head of patient services</td>
<td>Virtual</td>
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<tr>
<td>King Edward VII Pain Team</td>
<td>Claire Fear – Nurse&lt;br&gt;Suzanne Brook – physiotherapist&lt;br&gt;Jannie Van Der Merwe – clinical psychologist</td>
<td>Virtual</td>
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<tr>
<td>King’s College Health (KCL)</td>
<td>Amos Sims&lt;br&gt;Nurse &amp; Researcher</td>
<td>Virtual</td>
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<tr>
<td>Leeds Beckett University</td>
<td>Chris Kay&lt;br&gt;Senior Research Fellow</td>
<td>Telephone &amp; Virtual</td>
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<tr>
<td>Leeds NHS Trust</td>
<td>Karen Hardwick&lt;br&gt;Trauma psychologist</td>
<td>Virtual</td>
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<tr>
<td>Living Well With Pain, Northumbria NHS</td>
<td>Sarah Woods&lt;br&gt;Clinical Psychologist</td>
<td>Virtual</td>
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<tr>
<td>London Spinal Cord Injury Centre RNOH</td>
<td>Emma Linley – Clinical Specialist Occupational Therapist&lt;br&gt;&amp; Team Lead&lt;br&gt;Benita Hexter – Clinical Specialist and Lead Physiotherapist</td>
<td>Face to face</td>
</tr>
<tr>
<td>Loughborough University</td>
<td>Femindah Mieur&lt;br&gt;Researcher – health psychology</td>
<td>Virtual</td>
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<tr>
<td>Loughborough University</td>
<td>Mark Lewis&lt;br&gt;Dean of school and Professor of MSK Biology</td>
<td>Virtual</td>
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<tr>
<td>Midlands and East Veterans Op COURAGE: Veterans Mental Health and Wellbeing Service</td>
<td>David Powell&lt;br&gt;Regional Lead</td>
<td>Virtual</td>
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<tr>
<td>Ministry of Defence (MOD)</td>
<td>Peter Le Feuvre&lt;br&gt;Military Physiotherapist</td>
<td>Virtual</td>
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<tr>
<td>MOD</td>
<td>Dean Holder&lt;br&gt;OC at Tedworth House</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>MOD</td>
<td>Air Commandant Rich Withnall</td>
<td>Virtual</td>
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<tr>
<td>MOD</td>
<td>Anne Segalini&lt;br&gt;Lead Occupational Therapist&lt;br&gt;at Stanford Hall</td>
<td>Virtual</td>
</tr>
<tr>
<td>Organization</td>
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<td>Position/Role</td>
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<tr>
<td>MOD – Regional Rehabilitation Unit</td>
<td>Rob Canfer</td>
<td>RAF physiotherapist</td>
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<tr>
<td>MOD – Regional Rehabilitation Unit (Larkhill)</td>
<td>Andrew Taylor</td>
<td>Civilian Physiotherapist</td>
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<tr>
<td>MOD/NHS – Frimley Park</td>
<td>Col Alan Mistlin</td>
<td>MOD/NHS consultant in rheumatology and rehabilitation</td>
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<tr>
<td>MSK Best Collaborative</td>
<td>Fortnightly meetings</td>
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<tr>
<td>Musculoskeletal Association of Chartered Physiotherapists (MACP)</td>
<td>James Rogers</td>
<td>Professional Network Officer for MACP</td>
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<tr>
<td>Newcastle NHS</td>
<td>Nicola Stephens</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td></td>
<td>Lisa Robinson</td>
<td>Specialist Pain Nurse</td>
</tr>
<tr>
<td>NHS</td>
<td>Dr Sue Patterson</td>
<td>ED consultant</td>
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<tr>
<td>NHS &amp; Elite sports</td>
<td>Dr Chris Tomlinson</td>
<td>Consultant in Sports &amp; Exercise Medicine</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>Ian Ramsey</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>NHS E&amp;I South West</td>
<td>Juliet Ferris</td>
<td>Veterans and IPC</td>
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<tr>
<td>NHS England and Improvement</td>
<td>Dr Alf Collins</td>
<td>Pain specialist</td>
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<tr>
<td>NHS Solent – MSK Team</td>
<td>SallyAnn Smith – Clinical Manager</td>
<td></td>
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<td></td>
<td>Catherine Heather – MSK Pain Ops Lead</td>
<td></td>
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<tr>
<td>Norfolk and Norwich NHS</td>
<td>Leanne Millar</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Norfolk and Norwich NHS Trust</td>
<td>Laura Butler</td>
<td></td>
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<tr>
<td></td>
<td>Lucy Reeve</td>
<td>Occupational Therapist</td>
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<tr>
<td>Norfolk Community Health and Care NHS Trust</td>
<td>Lynne Fanning</td>
<td>Head of Clinical Education and Research</td>
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<td>Norfolk Community Healthcare</td>
<td>Linda Long</td>
<td>Lead Physiotherapist</td>
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<td>Norfolk County Council CCG</td>
<td>Merry Halliday</td>
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<td>Norwich’s Primary Integrated Community Service Ltd</td>
<td>Paula Banbury</td>
<td>Pain team lead</td>
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<tr>
<td>Oxford NHS Trust DSC</td>
<td>Sarah Holden</td>
<td>Specialist prosthetic Physiotherapist</td>
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<tr>
<td>Penzance – GP</td>
<td>Dr Boutler</td>
<td>GP and reservist (RAMC) and veterans champion</td>
</tr>
<tr>
<td>Physiquie</td>
<td>Andy Thomas</td>
<td>CEO</td>
</tr>
<tr>
<td>Plymouth NHS DSC</td>
<td>Gary Paret</td>
<td>Physiotherapist</td>
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<tr>
<td>Location</td>
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<td>Contact Method</td>
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<tr>
<td>Police Rehabilitation Centre in Goring</td>
<td>Ian Barron Physiotherapist</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>Police Rehabilitation Centre in Harrogate</td>
<td>Sarah Ward Lead Physiotherapist</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>Poole ABI Rehabilitation Service</td>
<td>Mark Smith Liz Parish Occupational therapist</td>
<td>Virtual</td>
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<tr>
<td>Portsmouth</td>
<td>Keith Malcom Armed Forces Covenant Lead Nurse Jan Hodgkinson DMWS</td>
<td>Virtual</td>
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<tr>
<td>Portsmouth NHS DSC</td>
<td>Chantel Ostler Sam Metcafe Manager</td>
<td>Virtual</td>
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<tr>
<td>Positive Transition</td>
<td>Tim Jones Armed Forces Covenant Lead Nurse</td>
<td>Virtual</td>
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<tr>
<td>Rehabilitation consultant at Salford and president of the British Society of Rehabilitation Medicine (BSRM)</td>
<td>Krystyna Walton</td>
<td>Virtual</td>
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<tr>
<td>Remaker UK</td>
<td>Humphrey Maddan Veteran and company Owner</td>
<td>Virtual</td>
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<tr>
<td>Robert Jones &amp; Agnes Hunt Orthopaedic Hospital (RJAH) – NHS</td>
<td>Lt Carl Meyer Orthopaedic Surgeon and army reservist</td>
<td>Telephone</td>
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<tr>
<td>Robert Jones &amp; Agnes NHS Hospital</td>
<td>Noel Harding Physiotherapist</td>
<td>Virtual &amp; face to face</td>
</tr>
<tr>
<td>Royal British Legion</td>
<td>Elizabeth Colliety Public Affairs and Policy Team</td>
<td>Virtual</td>
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<tr>
<td>Royal College of General Practitioners (RCGP)</td>
<td>Dr Robin Simpson Veteran Covenant Lead for Royal College of GPs</td>
<td>Virtual</td>
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<tr>
<td>Royal Cornwall Hospital – NHS</td>
<td>Dr Michael Butler Orthopaedic Surgeon &amp; Veteran</td>
<td>Face to face</td>
</tr>
<tr>
<td>Royal Cornwall Hospital – NHS</td>
<td>Dr Nigel Rayner Dr Chris Ireland Both GPs who also run the MSK interface service</td>
<td>Face to face</td>
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<tr>
<td>Royal Derby NHS DSC</td>
<td>Karen Clark Physiotherapist</td>
<td>Virtual</td>
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<tr>
<td>Royal National Orthopaedic Hospital (RNOH)</td>
<td>Anthony Gilbert Physiotherapist &amp; researcher</td>
<td>Virtual</td>
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<tr>
<td>RNOH</td>
<td>David Baxter Spinal Consultant &amp; serving Army doctor</td>
<td>Virtual</td>
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<td>RNOH – NHS</td>
<td>John Doyle Physiotherapist &amp; AHP Lead</td>
<td>Virtual &amp; face to face</td>
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<tr>
<td>RNOH – Pain service</td>
<td>Nicola Clancy Physiotherapist</td>
<td>Face to face</td>
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<tr>
<td>RNOH – Pain service</td>
<td>Greg Booth Physiotherapist &amp; researcher</td>
<td>Virtual</td>
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<tr>
<td>Location</td>
<td>Teams</td>
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</table>
| RNOH – Prosthetics | Jennifer Fulton – Physiotherapist  
                    John Sullivan & Morren – Prosthetist | Face to face |
| Royal United Hospital’s Bath NHS Foundation Trust | Gina Sergeant Head of therapies and professional lead AHP  
Dr Jeremey Gaunlett-Gilbert Clinical psychologist in the pain team | Virtual & face to face |
| Salford NHS | Lorraine Moore  
               Pain Physiotherapist | Telephone |
| Salisbury NHS Trust | Dr Alex Crick  
Plastic surgeon specialising in lower limb reconstruction. Runs the War Injuries Clinic for both serving personnel & veterans. | Virtual & face to face |
| Solent NHS Mental Health | Andrew Spencer  
               Armed Forces Lead Manager | Virtual |
| South Tees NHS DSC | Rachael McManus  
               Sally Smith | Virtual |
| Specialist Mobility Centre Preston NHS | Dr Fergus Jepson  
               Rehabilitation Consultant | Virtual & face to face |
| St Andrews Therapy Department, Mid and South Essex NHS Foundation Trust | Rachel Wiltshire – Lead Therapist for Burns, Plastics and Hand Therapy | Virtual |
| St George’s NHS Trust | Stephen Friend  
               Consultant Physiotherapist  
       Paul Marshall-Taylor Occupational Therapist  
       Ben Bowling Physiotherapist | Virtual & face to face |
| Suffolk County Council | Jim Brown | Virtual |
| Supporting Wounded Veterans | Ryan Knight  
               Team Leader – Pain Resilience Programme | Virtual |
| Sussex Partnership | Sally York  
               Primary Care Lead, FCP & Spinal Advanced Practice Physiotherapist | Virtual |
| Think Therapy | Helen Merfield  
               Nurse & Veteran  
               Steph Fleet Occupational Therapist | Virtual |
| Transition, Intervention and Liaison Service (TILS) | Andrew Millard  
               Occupational therapist & veteran | Virtual |
| UK ROC Health Service | Lynne Turner Stokes  
               Herbert Dunhill Chair of Rehabilitation. Director, Regional Rehabilitation Unit, Northwick Park Hospital. KCL Professor | Virtual |
| UK ROC Health Service | Carolyn Young  
               NHS E & I | Virtual |
<p>| UNITS Study | Dr Mary Keeling – Senior Research Fellow – Visible Difference and Military Conflict Research &amp; Sarah Evans – Research Associate Centre for Appearance Research | Virtual |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Role/Position</th>
<th>Delivery Method</th>
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<tbody>
<tr>
<td>University Hospitals of Derby and Burton</td>
<td>Lara Raworth</td>
<td>Project Improvement Team</td>
<td>Virtual</td>
</tr>
<tr>
<td>University Hospitals of Derby and Burton – MSK Group outpatients and vocational rehabilitation</td>
<td>Sarah Holt</td>
<td>Lead Occupational Therapist</td>
<td>Virtual &amp; face to face</td>
</tr>
<tr>
<td>University Hospitals of Derby and Burton – MSK outpatients</td>
<td>David Williams</td>
<td>Physiotherapist &amp; veteran</td>
<td>Virtual &amp; face to face</td>
</tr>
<tr>
<td>Versus Arthritis</td>
<td>Sarah Clarke Health Service Improvement Manager</td>
<td>Virtual</td>
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<tr>
<td>Veterans Growth</td>
<td>Jason Stevens</td>
<td>Veteran &amp; Charity Founder</td>
<td>Virtual</td>
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<td>Veterans Project Scotland</td>
<td>Keri Magee</td>
<td>Veteran and Project Lead</td>
<td>Virtual</td>
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<tr>
<td>Veterans Trauma Network (VTN) Wales</td>
<td>Bethan Hughes</td>
<td>Programme Manager</td>
<td>Face to face</td>
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<tr>
<td>Veterans Welfare Service</td>
<td>Emma Jones</td>
<td>Telephone</td>
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<td>Walking with the Wounded</td>
<td>Heather Saunders</td>
<td>Head of Employment</td>
<td>Virtual</td>
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<td>Walton Centre</td>
<td>Stephen Mullin</td>
<td>Consultant Clinical Neuropsychologist</td>
<td>Virtual</td>
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<tr>
<td>Warrior Programme</td>
<td>David Corthorn</td>
<td>Veteran</td>
<td>Virtual</td>
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<tr>
<td>York St John University</td>
<td>Nick Wood</td>
<td>Business development manager (Armed Forces and uniformed services)</td>
<td>Virtual</td>
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</table>

**Virtual Webinars / Conferences**

- Forces in Mind Trust (FiMT) – in their shoes  | January 2021
- Kings Fund – Developments in the NHS             | January 2021
- Kings Fund – Trust & Transparency in healthcare  | February 2021
- Blue Light Conference                           | February 2021
- KCL Conference                                  | March 2021
- Kings – virtual healthcare                      | March 2021
- Brighton Council Military Meeting               | March 2021
- FiMT – Transition of serving people and families | March 2021
- Health Innovation Exchange: innovation in rehabilitation Event | March 2021

**Together we can make a difference – Sussex Armed Forces Network**

- Champions Training
- Mental Health
- LGBT +
- Women
- Carer & Family
- Physical Health (Face to face conference)
- Brain Health – Online Webinar Series            | May 2021
- Crowdcast – Shellshock series                   | June 2021
- MSK – Improvement and Innovation                | July 2021
- Military Human Training.                        | July 2021
- Nick Wood, York St John University              | July 2021
<table>
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<tr>
<td>FCP Higher Education Webinar</td>
<td>August 2021</td>
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<tr>
<td>GP Teaching: Veterans Medicine (presented at)</td>
<td>October 2021</td>
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<tr>
<td>Poppy Conference</td>
<td>November 2021</td>
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<tr>
<td>British Trauma Society Conference</td>
<td>November 2021</td>
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<tr>
<td>Therapies Research and Audit Forum RNOH</td>
<td>November 2021</td>
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<tr>
<td>UNITS Dissemination Event</td>
<td>November 2021</td>
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<tr>
<td>Culture and Leadership Conference (British Army)</td>
<td>December 2021</td>
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